Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Stakeholder Input Process

General Stakeholders Meeting #6

Monday, September 25, 2006 in Sacramento, California
Tuesday, September 26, 2005 in Los Angeles, California

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Meeting Summary
For Discussion Only

I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery and wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

The general stakeholder meetings on September 25 and 26, 2006 were the sixth set of general stakeholder meetings for MHSA. The September 25 meeting in Sacramento and the September 26 meeting in Los Angeles used the same agenda.

123 people attended the morning meeting on September 25 in Sacramento and 91 attended on September 26 in Los Angeles for a total of 214 stakeholders. This summary reflects the combined content, questions and comments from both days' meetings.

II. Meeting Purpose

The purposes of the general stakeholder meetings on September 25 and 26, 2006 were to:

1. Provide updates on MHSA progress and implementation.
2. Solicit feedback on the Education and Training component.

III. Welcome, Introduction and Purpose of the General Stakeholders Meeting

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, welcomed the participants to the sixth set of general stakeholders meetings. She described the purpose of general stakeholder meetings: they are meant to update the community about progress on MHSA at the state level and to solicit feedback from stakeholders on aspects of the MHSA. Feedback from participants would be solicited in three ways: through discussion periods in the large group, small group discussions and written comments on special Education and Training topics.

IV. MHSA Progress and Updates

Carol Hood, DMH Deputy Director responsible for MHSA implementation, provided an update on various aspects of MHSA implementation. She acknowledged the involvement of stakeholders in the planning and implementation of MHSA at all levels. She noted that while a major goal for MHSA implementation was integration of all MHSA components (Capital and Technology, Community Services and Supports, Education and Training, Innovative Programs, Prevention and Early Intervention), it would be a gradual process to achieve that integration.

A. Implementation Timeline

Ms. Hood provided a written timetable of MHSA implementation, which can be found at the MHSA website, www.dmh.ca.gov/mhsa. She explained that it is an aggressive, but achievable plan that tries to balance the urgency of implementation against the need for planning and stakeholder feedback. Ms. Hood said DMH welcomes feedback through November 10, 2006 for specific suggestions for streamlining the implementation process. The color-coded timeline notes the specific points at which county programs will be funded.

Stakeholder Questions and Comments

- **Stakeholder Question:** It is questionable whether the IT committee of the Oversight and Accountability Commission (OAC) will continue to operate after January 2007 and yet there are large unresolved problems with IT. Security and privacy need to be addressed in a statewide subcommittee forum so that MHSA has a more secure path for information. How reporting and electronic medical records will be secure is critical. All documentation should be updated, including fingerprints and spyware. DMH and stakeholders need to address all these issues on a much broader spectrum: there have been only eight to nine people working on Capital and IT and there may be none after January.

- **DMH Response (Carol Hood (CH)):** There are other processes besides the OAC committee: counties, DMH and County Mental Health Directors Association (CMHDA) also have IT committees. DMH and the partners are trying to make that process more transparent. DMH does not know how OAC will handle its subcommittees.
- **Stakeholder Question:** If the OAC dissolves some of its working groups, could DMH absorb the members into the DMH committee? It would be a real tragedy for consumers and family members to become experts and then have no vehicle for ongoing input.
- **DMH Response (CH):** This is certainly something DMH will consider.

B. Stakeholder Process

DMH is now holding joint meetings with all partners identified by the MHSA legislation. These include DMH, the OAC, the Mental Health Planning Council, and the CMHDA. Ms. Hood noted that the MHSA partners had reaffirmed their commitment to seeking stakeholder input at both the state and local levels. Feedback has so far shown that people generally think that the stakeholder process to date has done a good job of articulating the MHSA spirit and values. There are concerns that the process has become too bureaucratic though. Many of the county plans got more complex and more bureaucratic.

There is concern that DMH is not reaching people or communities of color or transition age youth in the stakeholder process. DMH has committed to a new approach. Starting specifically with the Prevention and Early Intervention stakeholder process, DMH will work with contractors to conduct outreach to communities of color and transition age youth statewide to solicit their input. This input is likely to be gathered in venues different from these meetings. For ethnic communities, the contractors will likely hold sessions in those communities in languages other than English where appropriate. For transition age youth, the contractor will develop formats that will engage the youth.

Stakeholder Questions and Comments

- **Stakeholder Question:** Will John Ott be involved in this outreach effort?
  - **DMH Response (Carol Hood (CH)):** No.
  - **Stakeholder Question:** Is he mentoring others to do this work?
  - **DMH Response:** John Ott continues to be an important and valuable resource to us all.

- **Stakeholder Question:** Latinos often do not understand meetings conducted in English. Have some stakeholder meetings in other languages.
  - **DMH Response (CH):** DMH is able to provide interpreters at the meetings when requested in advance. While it has happened in the past, the people who use interpreters have not come back to subsequent meetings. DMH is anticipating some meetings within non-English speaking communities for the prevention and early intervention component.

- **Stakeholder Question:** At the October 2006 stakeholder meetings, there should be more people of color. Agencies are not bringing their own consumers of color to these meetings.
  - **DMH Response:** DMH is trying to engage the broad spectrum of stakeholders. MHSA is trying to reduce health disparities and wants to involve people who are disproportionately affected. DMH encourages the California Network of Mental Health Clients (Client Network) and other constituency groups to bring more people of color to stakeholder meetings.

- **Stakeholder Comment:** Stakeholders are trying to recruit more consumers of color into provider fields and yet DMH and community-based organizations (CBOs) cannot bring consumers of color to meetings. This misrepresents the voices of consumers. The Client Network does help. People with oppositional ideas do not get invited to meetings. In addition, my county is targeting veterans to prevent them from accessing MHSA funds.

- **Stakeholder Question:** How is the information gathered from stakeholders meetings incorporated in MHSA?
  - **DMH Response (CH):** A detailed summary is developed from each meeting, and posted on the DMH website within two weeks following each meeting. DMH's MHSA team reviews each stakeholder comment and considers how best to include it in the work at hand (CSS Plan, Education and Training Five Year Plan, etc.)

- **Stakeholder Comment:** Schedule and promote general stakeholders meetings a year in advance so that the advocacy organizations can arrange for their members to attend. Lack of adequate notices leads to inadequate outreach, lead time and notice to use scholarships. The Client Network did not have enough time to organize attendance and stipends. Provide a minimum of 6 weeks notice to bring clients to the meetings. Hold at least one general stakeholder meeting every three months. Hold a couple of statewide meetings rather than regional meetings, in order to allow consumers to get together to talk.
    - **DMH Response (CH):** DMH is developing a process that provides adequate notice to the Client Network and is trying to find a balance between moving quickly and being inclusive.

- **Stakeholder Comment:** Reinstitute consumer and family member pre-meetings to foster leadership and development.
  - **DMH Response (CH):** DMH has discussed and has gathered feedback from stakeholders about the purpose and continuation of consumer and family member pre-meetings. It appeared that these pre-meetings were not necessary. DMH will need further input from the Client Network about the purpose and importance of the pre-meetings.

- **Stakeholder Question:** How can one learn about these stakeholder meetings?

- **DMH Response:** The primary way DMH promotes general stakeholder meetings is through the website or through the MHSA mailing list. DMH sends out a weekly US Post Office mailing of new items on the website to those people who have requested to be on the mailing list and provided their names and addresses.

- **Stakeholder Question:** How does one get on the email list?
  - **DMH Response:** The toll-free line (within California): (800) 972-MHSA (6472); by fax: (916) 653-9194; by email: mhsa@dmh.ca.gov; by mail: ATTN: MHSA, California Department of Mental Health; 1600 Ninth Street, Room 130, Sacramento, CA 95814.

C. Regulations

The development of the regulations is in process. The typical cycle of regulation development includes the drafting and issuance of emergency regulations, followed by a public feedback period and concluding with revision and issuance of final regulations. The development of these regulations is a bigger challenge than expected. Regulations must be approved by state attorneys and pass several tests, including a clarity test. During the public feedback period for regulations, it is important that stakeholders provide input as to whether DMH has remained faithful to MHSA.

Stakeholder Questions and Comments

- **Stakeholder Comment:** In terms of emergency regulations, address conflicts of interest that affect consumer employees and confidentiality. Also county staff are creating a voter bloc against consumers.

D. CSS Implementation, Expansion and Annual Updates

DMH is reviewing the required CSS Annual Update, with an objective of making it shorter. The challenge is how to best use the required five to ten page limit, to capture everything that is a priority in each county.

So far, 52 counties have submitted CSS Plans and 43 have been approved. It is primarily the smallest counties that have not yet submitted their plans. There is a regularly updated map on the MHSA website that shows which counties have submitted plans and which have been approved. Many counties have begun implementation.

DMH is considering whether to stretch the initial three year CSS period into four years, since most counties were still planning and did not begin initial implementation of services in the original first year. If this change is made, the Three Year renewal will happen after the plans have been in effect for three years, not including the planning period.

There has been significant investments in services for transition age youth and older adults proposed by counties. In addition, there is likely to be more funding than originally anticipated. DMH is therefore looking at expansion funding for those counties that have the capacity to do so.

Stakeholder Questions and Comments

- **Stakeholder Question:** What is happening regarding the needs of people with severe mental illness who are homeless? They are most affected by stigma.
  - **DMH Response (CH):** Stigma will be worked on as part of the prevention component.
  - **Stakeholder Question:** How can stakeholders learn what how to participate in this work?
  - **DMH Response (CH):** Both DMH and the OAC are working on Prevention and Early Intervention, which will be the topic for the December 2006 and February 2007 stakeholders meetings. The OAC has a subcommittee specifically addressing this issue.

Expansion Funds

- **Stakeholder Question:** What is the timeline in CSS? When can counties submit expansion plans?
  - **DMH Response:** MHSA has more money than originally expected, both because additional revenues have been collected and the fact that counties have not spent everything expected. Expansion plan requirements will be rolled out between October 2006 and January 2007.

- **Stakeholder Question:** How much of the money for MHSA has been used and how much is left?
  - **DMH Response (CH):** One of the benefits about the current economy is that wealthy people are making money that is being taxed for MHSA. DMH was expecting $683 million for this year, but it looks like $1 billion will be collected. However, the way the funds flow means that MHSA does not have access to this money for two years. DMH is anticipating new dollars in 2007-08 that will allow counties to expand further, if they have the capacity.

- **Stakeholder Question:** How do stakeholders provide feedback about distribution of expansion funds?
  - **DMH Response (CH):** CMHDA is responsible for recommending principles for it, but suggestions are welcome at MHSA@dmh.ca.gov. DMH is exploring the best avenue to share information about additional funding: through a conference call or as part of the next stakeholder meeting or both.

Monitoring and Accountability

- **Stakeholder Question:** At the last general stakeholders meeting, there was discussion of reporting requirements and monitoring whether counties are following their plans and notifying DMH when changing them. Many counties with approved

plans are now making changes without DMH approval. DMH is apparently so busy still approving plans that monitoring has not started. Many people are disappointed that positions are being taken away from consumers and family members to become professionalized. What is DMH doing about monitoring?
  - **DMH Response (CH):** There are contractual agreements between DMH and counties with built-in flexibility. The MHSA website has a document that shows the types of changes counties must tell DMH about. DMH is in the early stages of developing a Request for Proposals for outside contractors to start the technical assistance process as well, to determine what is actually going on in counties rather than what the plan states. Approximately 800 to 1,000 consumer and family member positions have been designated in county CSS Plans, to date.

- **Stakeholder Question:** When will DMH hold counties accountable for consumer and family member positions and for everything in their plans, and are there criteria that they have to meet?
  - **DMH Response (CH):** DMH will have better answers to questions of monitoring in the next new months. However, DMH cannot hold counties accountable for what they cannot accomplish. They need a trained workforce and that is what today's meeting is about.

E. Expert Pool

Tina Wooton, DMH staff member, provided an update on DMH's Consumer and Family Member Expert Pool. The expert pool assists with different MHSA activities and provides input to DMH. In the last year, DMH expanded the pool from 71 to 171 people. The expert pool fulfills DMH's obligation under MHSA to include consumers and family members. The submitted CSS plans propose almost 1,000 positions for consumers and family members. Dr. Mayberg also noted recently that statewide over 100,000 people have helped out with the MHSA planning.

- **Stakeholder Question:** Is a list of members of the Expert Pool available?
  - **DMH Response (Tina Wooton (TW)):** This list is not available, but anyone seeking information should contact Ms. Wooton. If a county wants to form its own expert pool, DMH can help them to form one.

- **Stakeholder Question:** How does DMH assure diversity in the pool?
  - **DMH Response (TW):** DMH does not collect this data, but is constantly encouraging members to bring a diversity of people into the pool. DMH has reached out to county ethnic services managers to join and to reach out to their own communities.

F. Other Issues

- **Stakeholder Comment:** It is terrible that there is no food or coffee available at this meeting.

- **Pacific Health Consulting Group (PHCG) Response:** This is true. However, state regulations prevent the serving of food.
- **Stakeholder Comment:** Consumers, working with their counties, will try to resolve this issue for the next meeting.

- **Stakeholder Comment:** There is a new organization for mental health consumers of color.

- **Stakeholder Comment:** Close to 3,400 Californians die by suicide each year. Thus, California has its own "9/11" tragedy every year. There are three suicides for every two homicides and two suicides for every HIV/AIDS death. Research shows that up to 90% of those dying by suicide have a diagnosable mental disorder. The MHSA, Section 4, Part 3.6, calls for a program to reduce such "negative outcomes" as suicide. Suicide is the "worst outcome" of a mental illness. Since DMH and the OAC have responsibility under the law to provide treatment for those with a mental illness, you then have a moral as well as a lawful responsibility to provide for the safety of those you treat who are or may be suicidal. This means including suicide assessment and prevention programs with a client's treatment program. California cannot turn its back on those in treatment and in danger of self-inflicted injury or death. Please include appropriate suicide assessment and prevention components in all existing and new mental health treatment plans and programs. Further, you must ensure that those responsible for the treatment and safety of their clients have adequate education and training so they can carry out the MHSA's mandate to reduce suicide. Trainings have been developed by Suicide Prevention groups.
  - **DMH Response (CH):** DMH has been working with prevention and early intervention counterparts in the OAC because there is great overlap. Suicide prevention will get plenty of attention.
  - **Stakeholder Question:** What percent of prevention and early intervention will go to suicide prevention?
  - **DMH Response (CH):** This will have to be worked out.

- **Stakeholder Question:** Who is DMH contracting with for the housing component?
  - **DMH Response:** DMH is contracting with the Corporation for Supportive Housing (CSH). DMH is working with the California Housing Financing Agency (CalHFA), another state government agency. DMH has not provided additional resources to CalHFA.
  - **Stakeholder Question:** Will CSH be provided favorable status for bidding for county housing plans?
  - **DMH Response:** CSH is not a developer. CSH is the bridge between DMH and developers and supportive services.
  - **Stakeholder Question:** So when it comes time to build housing, will it be an open and transparent process?
  - **DMH Response:** Yes.

Voluntary vs. Involuntary Services Funded with MHSA

- **Stakeholder Comment:** The Client Network opposes the use of MHSA funds for involuntary short-term hospitalization for people in full service partnerships. DMH has stated that the impetus prompting them to consider this use for indigent people served by MHSA is that counties will have an increased burden for short-term hospitalization. The underlying rationale is that additional people who are served by the mental health system will require more involuntary commitments. This is flawed reasoning. It is also contrary to the expected outcomes for MHSA programs and the actual outcomes of AB 34/2034 programs, the model for MHSA. The emphasis throughout the CSS Requirements is on the importance of providing an array of client-driven, culturally sensitive, self-directed services that address the real life needs of people with mental disabilities. MHSA should decrease hospitalization rather than increase it.

  The existence of MHSA funds for involuntary in-patient treatment for people in CSS programs will further erode consumer trust. The success of CSS programs will depend on the level of trust between a consumer and his or her supportive environment. The knowledge that forced treatment hovers in the background will undermine that trust. It may drive people away from the system. The use of MHSA funds for short-term involuntary treatment for any reason or for any group of people defies the spirit and intent of the MHSA. The MHSA promise is to develop alternative ways of helping people in severe emotional distress, not look back to the same old unsuccessful answers. Use of MHSA funds for inpatient hospitalization is prohibited in the Act. The Client Network strongly urges the DMH not to adopt any addition to the MHSA CSS Requirements that would allow MHSA to be used for short-term hospitalization.

  In a series of focus groups conducted by the Client Network concerning discrimination and stigma in the state mental health system, the use of involuntary treatment was described as one of the most discriminatory practices. Since April 2005, clients have spoken in great numbers against involuntary services funded by MHSA and it was decided then not to use MHSA funds for involuntary services. The idea of an emergency regulation is to address a public safety concern. Emergency regulations that speak to short-term involuntary hospitalization funded with MHSA inflames the discrimination consumers are subjected to in all aspects of our lives and experiences.

  - **DMH Response (CH):** Issues concerning the use of MHSA funds for involuntary services are the most passionate part of the MHSA discussion. The issues of client choice on one hand and the belief of some family members that their family member is being unserved on the other hand oppose each other. This has been a very difficult debate. DMH has tried to indicate that services are designed to be voluntary, but that no one should be denied services based on their voluntary or involuntary status. Full service partnerships can pay for any services that are needed for an individual. At the same time, DMH stresses that it is a voluntary process. This is in conflict. If there is a need for short term hospitalization and the consumer has no other funding, then the full service partnership can pay. There will be time for people to give feedback on this during the regulation process. DMH staff are not aware of any counties that have asked for funding for this.

- **Stakeholder Comment:** Involuntary treatment should not be part of MHSA. Trust consumers. The counties and DMH need to earn the trust of clients. Instead they say one thing and say or do the opposite. The point of full service partnerships is that more organizations besides the state are involved. If the other partners do their job, then not everything has to be paid for by MHSA.
  - **DMH Response (CH):** DMH agrees that partners should pay for other things. But many clients are not on Medi-Cal and have no source of payment.

- **Stakeholder Comment:** DMH has been doing a delicate balancing act around the issues of use of MHSA funds for involuntary services. Funding has to be available to people regardless of their voluntary/involuntary status.

V. Education and Training

Warren Hayes, Chief of the Education and Training Unit of the MHSA, made a presentation about the status of the legislation-required Five Year Plan for Education and Training. He noted the significant participation by all the stakeholders in the plan development. Stakeholders have a sense of urgency about the importance of this component. He is working to balance the need for stakeholder feedback and getting started on the extensive needs for workforce development. The MHSA stipulates that California will develop a five-year education and training development plan (Five-Year Plan). The first draft clarified the mission, vision, values, goals and objectives. This second of three drafts added an analysis of workforce needs, accomplishments to date and actions for the coming year.

DMH is responsible for the development of the Five Year Plan. Review and approval is the responsibility of the Mental Health Planning Council. Oversight is the responsibility of the OAC. The document will remain in draft form until an inclusive stakeholder process is completed for all parts of the plan. The first draft was presented at the April 2006 General Stakeholder Meeting.

Since April 2006, the Education and Training Unit has actively engaged the involvement of subject matter experts. Individuals representing the following entities participated in the development of the second draft: California Institute for Mental Health (CIMH), United Advocates for Children of California (UACC), DMH MHSA Team, Office of Multicultural Services, professional mental health organizations, educational institutions and the DMH Expert Pool.

CSS Plan Analysis of Workforce Needs

- Over 4,300 new MHSA positions will be created statewide, according to an analysis of the submitted county CSS Plans; 20% of these positions have been specifically designated for consumers and family members.
- Hispanics, Native Americans and specifically designated immigrant populations have been identified as underrepresented in the workforce**.**

State Workforce Challenges
Cultural competency, language proficiency and diversity of the workforce were the most common challenges described by stakeholders. The next most common challenge was organizational capacity to support new services. Other challenges included the geographical challenges of recruiting staff and reaching consumers; hiring consumers and family members and recruiting and retaining licensed staff.

Planned Comprehensive Needs Assessment
The needs assessment will develop a method to analyze California's current community public mental health workforce education and training needs. It will establish a base line of occupational shortage and education and training capacity. It will develop a means to measure progress over time toward meeting California's workforce needs.

Accomplishments to Date
- Enacted a public planning process:
  - The Statewide Advisory Group endorsed proposed actions.
  - Special Topic Workgroups held over 20 meetings and teleconferences. Over 160 volunteers participated in these groups, including clients and family members, county staff, educational entities and professionals.
  - Public Input through the general stakeholders meetings.
- Developed MHSA Workforce Education and Training Unit Infrastructure.
- Implemented initial education and training resources, including renewal of and expansion of existing contacts with CIMH, UACC, National Association for Mental Illness – California (NAMI), and the Client Network, to support counties and contract agencies in the implementation of their plans through training and preparing consumers and family members for employment.
- Renew stipend with California Social Work Education Consortium (CALSWEC)
- 170 social workers graduated with a commitment to working in the mental health system who were supported by CALSWEC.
- Organizational Change Support: contracted with a consultant to help with the needs assessment and to work with the counties.
- Made progress on the Financial Incentive Program.

Actions for FY 2006-07
- Deliver expanded training and technical assistance available from statewide consultants and constituency organizations: CIMH, NAMI, the Client Network, UACC and DMH/Department of Rehabilitation (DOR) Training/Consultant Cadre.
- Fund community public mental health staff, education staff and consumers and family members to collaborate on local workforce education and training planning.
  - Establish Regional Partnerships.
  - Expand concept of the DMH Client and Family Member Expert Pool.
  - Plan mental health career pathway programs.
- Fund replicable model programs, which are an initial set of programs that are already providing excellent entry level preparatory programs, residency and

internships, certification programs based on psycho-social rehabilitation, and mental health career pathway programs.
- Convert relevant trainings into a blended learning format to enable Web-based access throughout California
- Establish structure for stipend, loan forgiveness and scholarship programs, working with the Office of Statewide Health Planning and Development (OSHPD).
- Maximize federal funding for existing scholarship and loan forgiveness programs in designated mental health profession shortage areas.
- Establish an ongoing MHSA education and training council.
- Promote the development of continuing education unit (CEU) trainings delivered in accordance with the Act.
- Review licensing/certification regulations/policies for opportunities to expand the number of qualified individuals capable of prescribing medications and overseeing treatment plans.

All MHSA funded education and training will be required to address how their program or training promotes cultural competency and includes the viewpoints and experiences of consumers and family members.

Next Steps
- Initiate expanded training and technical assistance now available from statewide consultants and constituency organizations, including marketing materials.
- Develop principles for funding and governance of MHSA Education and Training Component, working with CMHDA. Determine what will be funded at state, local and regional levels.
- Write emergency regulations.
- Conduct comprehensive statewide needs assessment to develop the totality of mental health employment and training needs.
- Release initial Education and Training Funds for workforce planning and replicable model programs.
- Write final draft of Five-Year Plan.

This is by no means a complete list and needs additional input. DMH seeks help to identify replicable programs.

Stakeholder Input Requested
- Comment on this second draft of the Five-Year Plan.
- Review and add to the list of training and technical assistance tracks and topics initially developed by the special topic workgroup.
- DMH will be inviting proposals for replicable model programs to be developed in the following areas:
    - Public mental health entry level preparation programs for consumers and family members
    - Residency and internship programs
    - Certification programs based upon psychosocial rehabilitation principles
    - Mental health career pathway programs

DMH is looking for answers to the following questions:

- Who are existing entities with potential replicable model programs?
- What qualifications, qualities and experience should a potential contractor possess?

In addition to today, feedback is encouraged through calling 916-651-0461 or sending an email to mhsa@dmh.ca.gov. Information on education and training will be posted at www.dmh.ca.gov/mhsa/EducTrain.asp.

Stakeholder Questions and Comments

Consumer and Family Member Training Topics and Issues

- **Stakeholder Comment:** Provide training for consumers about housing.

- **Stakeholder Question:** There is a fantastic peer training class in Riverside County. People are looking at issues of part-time vs. full-time work and not losing benefits. These are vital issues to work out. In addition, people have had trouble with dropping classes. There needs to be a way to prevent them from being a failure and providing Americans with Disabilities Act (ADA) assistance. How do we support consumers financially and help consumers back to school to be trained to be professionals?
  - **DMH Response (Warren Hayes (WH)):** This area is under study. Keep providing DMH with such information. This program sounds like it could be a model to share throughout the state.
  - **Stakeholder Comment:** Riverside County moved quickly to institute this education and training program, although it felt like it went very slowly.
  - **DMH Response (WH):** This requires stakeholders to work with Human Resources. It is important to share successes, to be realistic about time constraints and to work closely with partners.

- **Stakeholder Question:** Many people who had their first break in high school never learned how to participate actively. How will DMH address this?
  - **DMH Response (WH):** A recurring theme has been that the number one place to put money is in developing leadership and skills in how to participate in the process.
  - **Stakeholder Comment:** Consumers do not know the questions to ask to participate. Consumers, who are at a fifth grade level but are asked to participate on a college level, will be unable to participate. In the 80s, we closed the hospitals and gave people bus tickets to nowhere. Are we doing this again?

- **Stakeholder Question:** MHSA should help consumers earn advanced degrees so that we can be professional providers who are more sympathetic to consumers.
  - **DMH Response (WH):** This has been a consistent theme. There has not been an even playing field for this to happen. The strategy also has to help employers attract and retain employees in their agencies.

- **Stakeholder Comment:** There have been many setbacks in hiring consumers and family members because of the lack of training to do the work for the specific positions set aside for them. DMH needs to help consumers not lose benefits.

- **Stakeholder Question:** 800 new consumer and family member employees statewide sounds like a small number.
  - **DMH Response (WH):** In CSS Plans, counties had to complete a form stating the number of new employees as well as their commitment to hire at all levels. There are many transition and support issues to address.

- **Stakeholder Comment:** Page 5 of the second draft does not specify whether available funding is for consumers or current staff retraining. Clarify the ambiguity.

- **Stakeholder Comment:** The bottom of page 11 concerning stipends program background is great for low-income people.

- **Stakeholder Comment:** Who are the educators and who are the students? Which of us are the teachers and which ones of us have something to learn? In the answers to these questions lie the future of training. Make distance learning available so that consumers and family members can manage full-time work and education. How will consumers deal with school? Teachers are stigmatizing clients in behavioral health programs. Where is the education of educators? Where does it say college professors will be brought up to speed in terms of recovery and wellness? Consumers will benefit greatly from training on recovery, resiliency, and self-reflection. Many consumers are good at blaming others for their ills and for being victimized. Having good relationship skills is important to academia. Conducting ourselves well is necessary. Who will be the teachers and who the students in the transformed education system? Partnership would best be reflected in this draft as a mutual endeavor.

- **Stakeholder Comment:** Employ very specific language to address consumers and consumer involvement in education and training. With budget cuts, this is often cut first. Ensure that stipends for training and college tuition go to consumers.

- **Stakeholder Comment:** Train staff and consumers to provide support to consumers working in the system.

- **Stakeholder Comment:** Are there programs for clients as writers and artists? Provide significant flexibility in the education arena.

Higher Education Institutions

- **Stakeholder Comment:** Include community colleges, which train psychiatric technicians and nurses. So many people who attend community colleges are consumers. They need credit for their living experiences.

- **Stakeholder Comment:** So many consumers and family members are capable. They need to be teachers, not students.
  - **DMH Response (WH):** There are some really smart folks who know how to further this cross-fertilization. Community colleges are the perfect host for many trainings. The key is the right level of incentives to bring professors and consumers and family members together.

- **Stakeholder Question:** An ongoing concern about education and training is the issue of promoting a partnership between educational programs and mental health. The community colleges are best at providing education, not treatment to mental health clients. Community colleges support multicultural training. San Jose City College promotes education-based recovery, working with mental health providers. If community colleges are going to educate clients, MHSA has to teach them how to relate to education and teach educators how to relate to consumers. Teachers tend to say, "If you are stressed out, drop the class." There should be a component to train mental health staff to work with education-based recovery. San Jose City College wants to spread its model to other colleges throughout the state.
  - **DMH Response (WH):** DMH is still in the process of building a partnership between mental health and campuses to provide support on campuses for teachers and students. The Education and Training Unit intends to have some very concrete plans in the next draft of the Five Year Plan. There is much to be done about post-secondary education in the long-term. DMH's Education and Training Unit has heard from many organizations saying, "We can do this, we are interested in participating." The process will be very transparent. The challenge is to determine what programs DMH funds that are replicable at the state level, and what happens on a local or regional level. By spring 2007, there will be a roadmap. Anyone who thinks they are part of the solution should step up.

- **Stakeholder Comment:** San Jose City College supports an academic point of view, but does not provide student support.
  - **DMH Response (WH):** If MHSA tries to change curricula, it would have to move school by school, but building a partnership of curricula developers will lead to transformation.

- **Stakeholder Comment:** It is important to bring the education and training components up to speed as soon as possible, especially at community colleges. There is a lot of concern about the traditional approach professors use across the state. It is important that people with real experiences are involved as co-trainers and co-presenters in the training. Academic training is not the only component. Having real life experiences should be "credited."

Cultural Competence

- **Stakeholder Question:** Diverse groups are under-represented in the planning process at both state and local levels. These groups must be included. It is difficult but is a requirement of MHSA. Cultural competence begins with inclusion of the

under-represented groups, which is not happening, especially with Education and Training. This is true not only with consumers and family members, but with the whole workforce. There must be a very strong emphasis at the organization level to work with diverse populations and hire diverse staff. Is there any way to move this forward?
    - **DMH Response (WH):** Education and Training is not there yet. One of the clear consensus agreements is that Education and Training stresses cultural competence, which will be cross cutting in each special topic area. There were voices of diverse people participating in special topics, but not at the percentage of their representation in the statewide population.

- **Stakeholder Question:** In terms of these model programs, will DMH limit selection to those programs that are ready to expand but are not culturally competent or will it include more culturally competent ones that are not ready to expand immediately?
    - **DMH Response (WH):** In DMH's Request for Proposals, programs with cultural competence will be a very clear goal. CalSWEC, which was awarded $6 million early on, had an excellent track record of recruiting and supporting a diverse population. Their surveys show that their students committed to public health closely mirror the statewide population. When looking at new programs, cultural competence will be one of the primary evaluation criteria.

- **Stakeholder Question:** There are questions about the education of people who are going to work with Native American consumers, who are such a special class of people. The education provided by regular schools will never meet the needs of Native Americans. White Americans will never understand the trauma Native Americans experienced by the occupation of our lands. Until White people can understand this, things will not change. It is very slow work, requiring significant sensitivity. Most people are not equipped to deal with the Native American community at all. Outside of the African American culture, there is no other group who understands what Native Americans experience. The organizations DMH lists cannot appropriately serve Native Americans. Will DMH require that the schools will educate themselves about what has happened in the United States? If not, then the programs will not be successful. If DMH expects the counties to step up, it will not work. There are ways to reach Native Americans, but none have been seen here. Accept information from native people; they are the ones who know what is happening and know how to develop a program to meet the needs of their people. These programs being developed in the name of Native Americans are useless.
    - **DMH Response (WH):** If the mental health system continues to do things it has been doing, it will not connect with Native American consumers. DMH is committed to do things differently and to bringing in the community to help us.

- **Stakeholder Comment:** On page 9, change "monolingual" to "non-English speaking."

- **Stakeholder Comment:** Input from communities of color seems to be lacking. There are a number of statewide organizations that should be part of the input.

- **Stakeholder Comment:** In terms of cultural diversity among immigrant communities, there is no emphasis on Slavic languages. Slavic immigrants seem to be invisible.

Rural Issues

- **Stakeholder Question:** Concerning page 12, regional partnerships will not work for small, rural areas. Transportation is a big problem in small rural counties. Often small isolated areas need to be able to work with CalWORKs and the Employment Development Department (EDD) in order to have computers and internet. However, CalWORKs will not help people on Social Security. Recognize how understaffed small counties are. The Alliance for Workforce Development might help.
    - **DMH Response (WH):** County memberships in regional partnerships will not be defined by the Five Year Plan. DMH wants to facilitate counties working together. DMH has heard lots of input about what regional partnerships should or could look like. CMHDA recognizes that small counties may need a base amount for Education and Training, so that they get sufficient dollars to send even one person for training.

- **Stakeholder Comment:** Other small county issues include major barriers for certain cultural language groups and access to resources to stay in the education process. Small rural counties do not have the resources to provide support or be able to address these issues. What is being done to put the funding in the hands of the target groups?

- **Stakeholder Comment:** In discussing what kind of credentials and what kinds of contractors would best serve clients, it should be a given to serve all geographic areas. Rural areas often get lost in the mix.

Criteria and Requirements

- **Stakeholder Comment:** What has DMH done to influence the Council of Social Work Education? Getting them to add certain requirements about wellness and recovery for example is the fastest way to bring about change. Educators pay attention to changes in these criteria.

- **Stakeholder Comment:** There is no California Masters level professional counseling license. This needs to change. The California State Universities produce Masters Degree people of whom 50% are people of color. Licensing in the 28 states with Masters Degree licenses have a cultural competence requirement.

- **Stakeholder Comment:** Why is there an assumption that people with Masters in Social Work (MSW) are the best people to be in management in behavioral health organizations? A few more bean counters are needed. Educate consumers to be psychiatrists, psychologists and counselors.

Community Health Centers

- **Stakeholder Comment:** Community clinics are part of the solution as primary care providers who also provide mental health services. In the needs assessment, look at community health centers as a potential source of providers, because they employ hundreds of mental health providers. Acknowledge the capacity of community health centers to provide culturally appropriate mental health services.

- **Stakeholder Comment:** Include community health centers as a target for training resources. Community health centers, as a network, serve 70% diverse populations of whom 42% speak other languages. Community health center providers could use more training. Target resources to this statewide network of hundreds of providers.

- **Stakeholder Comment:** Without adequate prescriptive language, regional partnerships will not happen. Counties need to reach out to those that already have functioning associations. California community health centers have 14 regional clinic associations, which could be an infrastructure for getting training out to the community.

Organic Brain Disorders

- **Stakeholder Question:** Make the funding available to train mental health staff and contractors in identification of fetal alcohol spectrum disorders (FASD). Fund the right programs for children with FASD to attend. Studies show that 93% of all people with FASD have co-occurring mental health disorders. Intervention prevents suicide and other issues.
  - **DMH Response (WH):** There will be a combination state-local partnership for training. Tell DMH if there are specific areas that need to get on the map.
  - **Stakeholder Question:** How does adequate education about FASD get into the textbooks?
  - **DMH Response (WH):** It is a long-term task to build relationships with educational entities. This must include infrastructure capacity building.
  - **Stakeholder Question:** Whom do you call? We need it in textbooks.
  - **DMH Response (WH):** We want to fund regional partnerships so that families can have a voice to get this information into the textbooks.

- **Stakeholder Comment:** There needs to be a paradigm shift between mental health and learning/behavior theory. Organic brain disorders need to be addressed appropriately.

Consumer Movement

- **Stakeholder Question:** Is there replicable training to support consumer-run programs? Attention needs to be paid to create a paradigm shift.
  - **DMH Response (WH):** This is another key theme. California is blessed with a number of good programs. DMH needs to assess how to help them grow and expand and plant new seeds and programs.

- **Stakeholder Comment:** The mental health system does not know how to support the consumer movement and the consumer movement does not know how to be a consumer movement.

Other Issues

- **Stakeholder Comment:** What is happening here? This plan will send people to the existing programs that train people to send people to involuntary treatment. These programs need to train people on how to work with voluntary treatment programs. What is the ethical base of this? Who is in charge? Why is this being left for last?

- **Stakeholder Question:** Is there a booklet that shows all the details of the Education and Training program?
  - **DMH Response (WH):** This is the second of three drafts. The final draft will have specifics of the five-year plan.

- **Stakeholder Question:** Los Angeles County Mental Health is in the midst of an embarrassing sequence of events to hire consumers and could use help from DMH. While Mental Health is a system in transformation, Human Resources are a system in stagnation. Human Resources is refusing to acknowledge the status of consumers and family members as a bona fide job qualification. Please share job specifications from other counties.
  - **DMH Response (WH):** DMH regrets to hear this, but knows that Los Angeles is not the only county experiencing this problem. How to address these barriers? Education and Training is gathering expertise to assist in how to address these barriers. The idea of sharing terminology of successful job specifications is a great strategy.

VI. Feedback for Five Year Plan

A. Training and Technical Assistance Tracks and Topics

The following represents an initial set of broad tracks for training and technical assistance appropriate for MHSA. Stakeholders were asked to provide written feedback on these topics, based on the examples provided. The items identified with an asterisk (*) at the beginning of each section below were provided by DMH as a memory spur for the topic area.

1. Recovery, Wellness and Resiliency

* Facilitating recovery-oriented mental health service delivery
* Assessment and treatment of co-occurring disorders
* Assessment and treatment of trauma
* Integration of physical and mental health treatment
* Using alternate treatment modalities to decrease medication need

* Sharing innovative/best/promising/evidence-based practices

Stakeholder Feedback

Facilitating recovery-oriented mental health service delivery

- Anti-stigma and discrimination: Include more consumer and family member panels with personal stories. This puts a face on mental illness and moves us forward.
- Design new services with the goal of eventual exit to community involvement and natural supports with a safety net for services as needed.
- Provide funding for training for clients to develop, run and systemize client-run self-help centers. Training topics should include team building, lateral leadership and creating services that attract clients who have free choice.
- Training and technical assistance is needed in consumer-run and alternative programs and services such as self-help, peer and mutual support programs. The use of the term “treatment” is counter-productive to recovery. Please use the term “programs and services.” Treatment is based on clinical models.
- Offer training to include clients in all aspects of community, including peace, eco-sustainability, building green culture and leadership.
- Offer training in non-violent communication literacy.
- Offer training on Emotional Quotient.
- Offer training in self-reflection.

Assessment and treatment of co-occurring disorders

- Address co-occurring disorders, including developmental delay.
- Provide training in FASD to improve the efficacy of treatment and to decrease the cost of failed interventions.
- Add extensive language about FASD in textbooks.
- Screen for alcohol use and abuse and fetal alcohol spectrum disorders and organic brain difference which becomes cognitive difference.
- Co-dependency.

Target Groups

- Recognize that Asian consumers are significantly different from “Western” consumers. They need and expect more structure and support. As a result, the model Wellness Centers that are totally client run may not be as trusted by Asian and Pacific Islander consumers. This runs counter to many mainstream consumer advocates’ points of view. Cultural sensitivity demands more diverse possibilities that are not solely evidence-based methods.
- Work with Older Americans Act Senior Employment programs that provide for subsidized placement of older workers. These are grant-funded older adult training programs.
- Employ retired older adult skilled professionals returning to the workforce (nursing, social work, etc.)
- Much of the conversation has not included non-county or county contracted mental health providers, such as free and community clinics and federally qualified health centers (FQHCs) which mainly provide primary care, but also mental health

services. Include these providers in any statewide assessments of occupational capacity, as well as workforce and training needs.

Ethics

- Offer training in ethics.
- Examples of unethical treatment: Heard in the hall: Said to a consumer employee by "normal" staff member, "Won't we have fun with you next time you are hospitalized." Also, "You cannot associate outside work with mental health clients because they might be your clients."

Using alternate treatment modalities to decrease medication need

- Develop bachelor's degrees in stress reduction therapy, relaxation techniques and creative arts therapy.
- Develop arts training for facilitators in mental health, including "telling our stories" through theater, visual arts, music, computer arts, dance, nature-based rituals, etc. These are excellent modalities to support wellness and recovery. Use certified and trained Art Therapists on the teams.

Sharing innovative/best/promising/evidence-based practices

- Alternative and holistic treatment modalities are absolutely needed for recovery, wellness and resiliency. Models for such services that already exist include the Stepping Stone Crisis Respite Center in New Hampshire, which offers client-survivor-driven respite services as an alternative for hospitalization for people experiencing emotional distress.

Integration of physical and mental health treatment

- Integration of physical and mental health treatment in this age of discrimination and stigma will likely increase the frequency of discrimination against mental health clients and survivors by primary care providers. In the Client Network focus group study, participants reported discrimination from primary care providers who had learned of their mental health histories. This discrimination often takes the form of dismissal or discounting of clients' complaints of physical health problems, based on providers' assumptions of hypochondria or delusion. Also knowledge of the client's history of hospitalization has been linked with a greatly increased risk that that client may be involuntarily committed by their primary care provider if they show signs of anger, anxiety, disassociation, etc.

Other Issues

- There are still secrecy and hidden agendas rather than transparency in place in counties. Please address this.
- It is really a shame that present mental health staff are looked upon so negatively at these meetings. There seems to be no recognition or compassion for how hard it is to be in the mental health professions right now. Change is necessary and the recovery model is positive, but let's recognize everyone's participation in the process.

2. Consumer Support

* Supportive housing
* Supportive education
* Employment with supports
* Understanding and encouraging self-help and peer support

Stakeholder Feedback

Specific Training Ideas

- Provide training for consumers including
    - Wellness and recovery
    - Alternative/holistic care
    - Non-violent communication
    - Relationship skills
    - Self-reflection/meditation/spiritual practice
- Provide training to bring together family members and clients who want to reunite. Among issues to be discussed are:
    - Role of confidentiality
    - Role of service providers in facilitation of communication between parents and children
    - Facilitating growth to adulthood in developing respected social role
    - Encouraging parents to see the importance of choice and voluntary services.
- Provide self-advocacy training to help clients find their own voices.
- Provide training programs for all levels of employment: pre-employment training, entry level training, ongoing training programs as well as GED, community college and certificate programs.
- Provide training in organic brain dysfunction and fetal alcohol spectrum disorders.

Monitoring

- Monitor the implementation of county hiring practices in terms of fairness. My county does not provide equal and fair employment opportunities to all consumers. The county only provides employment opportunities to its own circle of consumers who will follow their direction and compromise.
- My county needs to improve its accountability to clients. It does not provide channels for all consumers to participate or to address their opinions. The hiring process was also pre-selected and pre-arranged for those who will obey them.
- Two rural counties that have no resources for the severely mentally ill adults and transition aged youth already present and suffering, have chosen to focus MHSA programs on children and seniors in order to maintain business as usual. What is DMH doing to address this?
- When basic needs are not addressed in the plan, how is the DMH review team responding?

Employment Supports

- Assist with transportation to educational programs.

- If clients who enter the workforce do not experience ethical treatment and practices, they will be scapegoated for every mistake.
- Sometimes consumers have bad days and call in sick to work. A program in Phoenix called “Cheers” encourages them to come in to work even if only for a few hours, or even come in if they do not feel they can work, just to be around people. Also, they may feel very pressured to take the first available job; if it is not a good fit, they feel scared to leave it. Flexibility and open communications are key.
- Facilitate informed decisions about benefits while transitioning to work.

Concerns about Supports
- All of these “support” system programs and services must be designed, implemented and administered by those with life experiences.
- Caution must be taken in designing and implementing supportive housing programs to avoid restrictive and punitive program models, such as visitor policies that make it difficult for low-income people to have family and friends visit them in their homes and other restrictions that are paternalistic and lead to preventable 5150s, evictions and arrests.
- Consumers want to be in control of their lives, not have professionals in control. Professionals should be there to support clients, not control them.
- Use peers working with and training peers.

Training Issues
- Training for peer support means facilitating networks of local and regional leadership support. Within these networks, training needs can be more precisely identified and met. “Training” as a static deliverable is most often misplaced in this paradigm shift.
- Expand certification programs to include more than Drug and Alcohol Treatment Programs. Mental illnesses are presented in all forms in various behaviors, not just alcohol and drug issues. Do not exclude other co-occurring illnesses.
- Screen for alcohol use and abuse and FASD.

Target Groups
- Train supervision/management level staff on the value of employing consumers and family members. They need training on developing positions, including writing clear position descriptions and how to provide ongoing support so consumers and family members can succeed in their positions.
- Support newly diagnosed older adults.

3. Consumer and Family Member Partnership

* Employing consumers and family members
* Peer and family support services
* Development of career ladders
* Leadership training and development at all levels
* Training provided by consumers and family members

Stakeholder Feedback

Training Provided by Consumers and Family Members

- Clients have developed several trainings in the Bay Area to reduce discrimination and stigma among mental health professionals, social workers, rape crisis counselors and advocates and hotel desk clerks. These can be found at www.groups.yahoo.com/group/MH_101, and http://strategiesforchange.googlepages.com/events#presivat.
- Employment of clients must be at all levels. The training of staff must use curriculum designed by clients.
- Train and support supervisors and managers to develop a workplace that is welcoming to consumer and family member employees and to learn effective supervisory strategies.
- Prepare the existing workforce to work with consumers and family members.
- NAMI is the only family member contact list. To get a cross section, consider Mental Health Association, Depression and Bipolar Support Alliance (DBSA), obsessive-compulsive disorder (OCD) support groups, anxiety support groups and bereavement support groups.
- Provide training in FASD and organic brain dysfunction and perhaps family support groups through NAMI.

Employing Consumers and Family Members

- Will DMH provide guidelines to county mental health departments as to the types of position (jobs) being developed for consumers and family members?
- Expand the employment capacity of the expert pool members and make recommendations and referrals to each county on the hiring of expert pool members at the regional level.
- Do not set up a failure situation. Create an employment model to meet consumers where they are at present time. Foster confidence building with anti-stigma training to all employees, consumers and nonconsumers. Consumers already understand the issues.
- Develop jobs based on ability to do the job, not based solely on the initials after a person's name. Education does not always equal competence.
- Include older adults in the age groups, not just adults and children.
- Use older adult workers to meet workforce needs.

Peer and Family Support Services

- Provide training on how to go back to work without losing benefits.
- Provide ongoing supports for consumers and family members.
- Foster working together with a team approach and no loss of rights or confidentiality for all ages.
- Assure that mental health programs and services are provided at the client's cognitive level, including checking for understanding.

Monitoring

- San Mateo County does not include and value consumers' opinions equally to other staff. How do stakeholders demand that counties include all kinds of consumers' voices and assure they will not retaliate against consumers who have different opinions from their counties' mental health department? And how do we make sure these counties follow the compliance "truthfully?"
- Should these types of services be part of all MHSA Plans? When they are not included, what happens? Does DMH insist these important supports be in each plan?
- In some counties, there have been limitations on many services. How will this be addressed or even discovered by DMH?

Development of Career Ladders
- Consumer providers need living wages and meaningful jobs.
- Consumers must be able to have careers and real benefits, not just dead-end jobs that pay almost nothing.

4. Outreach and Cultural Competency

* Outreach and engagement to underserved/unserved populations
* Building community teams to serve target/special populations/age groups
* Assessing cultural competency and training to targeted needs
* Recruiting and retaining culturally competent staff
* Language proficiency strategies

Stakeholder Feedback

Outreach and Engagement to Underserved/Unserved Populations
- Outreach to the deaf community.
- Go into inner city high schools with large, diverse populations to encourage students to become mental health professionals.
- Recognize that older adults also need staff who are culturally competent.
- Outreach and cultural competence does not appear to include all unserved, under-represented consumers.
- Collaboration between Native American Medical Centers located on reservations and DMH might lead to more representation from Native Americans. Promote more collaboration within county and state mental health departments.
- Older adults and clients with multiple disabilities need ADA supports.

Assessing Cultural Competency and Training to Targeted Needs
- This is one of our greatest needs and concerns.
- Create first steps templates for approaching local ethnic and cultural leaders to learn their needs. Require counties to report the results of their use of this template. Include state level ethnic groups' suggestions for outreach and service delivery in the template-driven discussion to get local feedback.
- Provide anti-racism training: how racism still works today and how to undo it.
- Diversity in the workforce: DMH cultural competency representatives are not credible. Some counties' cultural competence committees do not have the "right

representations." In one county, as long as the recruiters look black, Latino or Asian, these staff are considered culturally competent.
- Depression of older adults must be addressed.
- Asians and Pacific Islanders are rarely and poorly represented. Simply to put some famous Asian figure on the OAC is inadequate: it is fake and tokenized. A lot of the leaders at DMH are very snobbish and discriminatory themselves.
- Do not forget client culture when thinking about cultural competence.
- Inclusion: how are the clients and minorities going to become the teachers and not the students? The system needs teaching.
- Counties do not truly value voiceless consumers because these groups of consumers do not know their own rights.
- Native Americans view alcoholism problems from an entirely different framework than other cultures.
- Promote gay, lesbian, bisexual and transgender (GLBT) awareness.

Recruiting and Retaining Culturally Competent Staff
- The recruitment or retention of culturally competent consumers to become DMH staff needs to be addressed at the state and local levels. Beginning with DMH is crucial.
- Not only is there a significant need to attract a more culturally diverse workforce, it is also important to recruit a more professionally diverse workforce who are trained to address growing needs in the area of gerontology, rehabilitation counseling, forensic counseling, etc. Consumers' needs in these areas cross all cultural lines.
- It is important to remove barriers to licensure. Licensed Professional Counselors exist in 48 other states but not in California or Nevada. California State Universities train these Masters level counselors who cannot get hired for certain positions reflecting their level of education and training unless they have a license (currently limited to MFTs and LCSWs). Often the passion or expertise and experience to work in counseling areas for the underserved is diverted when students learn of licensing barriers and the resulting employment barriers. They may move to an MFT track or leave counseling all together. From a cultural diversity standpoint, more than 50% of Masters level counselors are people of color.
- Hire more African Americans in the psychology field. They are under-represented in mental health. Train them from college on through doctoral programs.
- Improve public relations for psychiatry to recruit, train and hire African American and Latino psychiatrists.

Training Recommendations
- Clinicians must become open-minded about honest communication with clients and must realize that most people do not speak or think the way they do.
- Free and community primary care clinics and FQHCs already provide high quality, culturally and linguistically competent health services to low income and underserved communities. Dedicate part of the education and training funds to existing community providers such as these who already have the expertise in providing mental health services to culturally and linguistically diverse communities.
- There is no place in all these lists to explore issues of ethics.

- Programs provided under MHSA should be appropriate for the cognitive level of the client.
- Provide training on CSS Plan analysis of workforce needs and on how to meet them.
- Create warm lines, not suicide lines with peers helping peers.

5. Prevention and Early Intervention

A. Content Knowledge and Strategies

* Resiliency, self-regulation and other universal education and skill building to promote mental health
* Early identification and intervening
* Stigma and discrimination reduction
* Suicide prevention
* Mental health integration in schools
* Mental health integration in primary health care
* Mental health integration in community services
* Children and youth in foster care
* Trauma
* Maternal depression
* Prenatal to three brain development and attachment/connectedness
* "First Break"
* Strength-based positive parenting
* Peer and group supports

Stakeholder Feedback

Training and Education Topics

- Assure consumer education in order for consumers to work together on all subtitles listed above.
- Assure training for preventing crises and getting clients the services they choose rather than diagnosis-driven, medical-based, stigmatizing coercive treatment that results in trauma and distrust.
- Add co-occurring issues such as drugs and alcohol.
- Expand mentoring capability for all ages.
- Include proper education on nutrition to achieve proper weight and ultimate energy. Hope is a formula for ultimate health.
- Provide training for innovative open-door "Stress Motel": a voluntary holistic respite center in the community that allows for true healing of the whole person and reintegration into the community.

Older Adults Needs

- Do not forget older adults for prevention and early intervention programs. They have the following needs: late onset psychosis, prevention of depression, prevention of unnecessary institutionalization, prevention of suicide (they have among the highest suicide rates).

- Address older adult aging transitions and multiple losses.
- Assure integration of chronic medical disease treatment and mental health services for older adults.
- Address needs of newly diagnosed seniors through prevention and early intervention to prevent hospitalization and suicide.
- Include older adult and senior mental health screenings and programs.
- Include geriatric competency practice skills: core competencies for geriatric practitioners.
- Staff need training to work with older adults.

Prevention and Early Intervention Issues

- Address the high rate of Latina suicide attempts and high rate of Asian American transition age youth suicide rate through programs such as the Iris Alliance.
- Address poverty, domestic violence, child abuse and neglect, and substance use disorder.
- Prevention and early intervention should also help to avoid forensic incarceration for all ages.
- People having their "first break" often end up in jails. Immediate identification by health and mental health staff to place these people in an appropriate treatment setting is critical. Often they have not entered into any (county) treatment and have not yet been diagnosed.
- Scientific literature shows that long term outcomes are greatly improved when a person having a "first break" is "aggressively" treated at this phase. Physicians are very hesitant to make a diagnosis and the person does not get the right medication for the right amount of time.
- Address the needs of transition age youth and children.

Curriculum Resources

- Bonnie Benard from WestEd has done work on resilience: Resource to Intervention in Schools.
- Cognitive Behavioral Intervention to Trauma in Schools (CBITS) by Marlene Wong of Los Angeles Unified School District/RAND/UCLA is a model.
- SOS by Carmen Lee from CMHPC is a resource.
- See Dr. Larry Burd at University of Dakota, www.on-lineclinic.com.

Other Resources

- Crisis hostels where peer support and other services are available. Require crisis hostels as part of county plans.
- Include more community levels of care, for example, urgent care centers, client-run crisis houses to prevent hospitalizations.
- Use of peer bridges to prevent rehospitalization.

Team Approaches

- Work with Bureau of Public Health Care (BPHC) Health Disparities collaborative programs and mental health integration as models.
- Include parent experts in FASD and recovery and self-advocates.

- Mental health staff need to implement client ideas.

Anti-Stigma
- Fight negative stigma to make it easier to ask for help. Shift the blame.
- Promote anti-stigma campaigns that emphasize mental illness as a developmental process and challenge.

Staff Issues
- Increase nurses, social workers and special education staff.

B. Management, Coordination and Consultation Skills

* Meeting basic needs (food, housing, transportation, income)
* Funding streams and resource leveraging
* Coordinated child/family services and community linkages; skills of collaborative partnerships
* Analyzing prevalence data
* Managing facilitation
* Consultation models for early childhood educators, K-12 educators, healthcare staff, law enforcement personnel

Stakeholder Feedback

Target Groups
- Everyone needs prevention and early intervention help, not just children.
- It has become quite apparent that DMH is not paying attention to adults and older adults in this area. This is about prevention so people can stay out of hospitals and jails and education, supportive housing and support groups.
- Develop peer support for adults with medical problems as they transition to older adults.
- Adjust prevalence data to accurately reflect older adult prevalence data.
- Work with family preservation and other groups to support children who are at risk.
- Train and certify school district mental health counselors in neuro-cognitive difference and FASD. Train them to screen for alcohol abuse and FASD at school sites or mental health facilities serving these clients.

Other Issues
- Raise consumers' pay rate. DMH needs to encourage the hiring of mental health consumers and be an honorable model to the counties that DMH pays consumers fairly, including medical benefits, etc. Ten dollars an hour is very unkind.
- Expand involvement with other grassroots consumer and family member groups. The Client Network and NAMI are making money and gaining their own profits at the expense of the grassroots consumers who do not have any affiliations with these groups.
- Can counties use MHSA training money to pay for trainings they would normally do within current budgets?

- Who will train the educators in what is really needed to develop the training curriculum?
- Develop a pool of client and family member consultants.
- Regional partnership structures should include identifying opportunities to contact regional primary care clinic associations, which serve as a strong voice for FQHCs and free and community clinics, many of which provide mental health services already. These can be a successful and replicable model.

6. Infrastructure

* Leadership skills training
* Supervision and management training toward successful outcomes
* Developing business and administration skills
* Increasing information technology capacity and capability
* Data management and using data to manage
* Recording the treatment/service process

Stakeholder Feedback

Cultural Competence

- Obtain Native American education from the tribal leaders. We need more education for the Native American as they were here before the white man and are treated unjustly.
- This Education and Training development process did NOT include enough consumers' opinions and needs more culturally diverse representation.
- In analyzing data, remember to disaggregate Asian ethnicities.

Leadership/Supervisory Training

- Increase the number of mental health clinical supervisors available. This level of staff is in short supply.
- Provide training for supervisors.
- There are recovery-based theories to guide all levels of leadership.

Consumer Issues

- Financial incentives for organizations, such as reimbursement for employee release time, should be considered in planning for training and technical assistance. If that is the case, they are getting paid to go to school plus their school is free. What about the consumer? Where would the consumer benefit?
- Consumers know better than anyone what goes on in the lives of consumers and family members. Consumers should be given "expert status" and afforded respect as such. We should also be educated and employed as equals with existing staff members.

IT Needs

- Many of the smaller CBOs do not have the funding to be computer competent. Current DMH funding does not allow for money to buy equipment and technical assistance. This needs to be funded.
- Compile and publish minimum IT specifications so critical data collection and management can occur and outcome measurement and performance factors can be developed and evaluated.

Professional Training Needs
- Train current professionals to work with and mentor their clients: conduct 'train the trainer' programs for mental health professionals.
- Revised questions on licensure exams to capture or reflect the change in curriculum in social work and MFT graduate programs. California Board of Behavioral Sciences (BBS) needs to revise exam to include values of resilience, recovery and wellness and co-occurring illnesses.

7. Other Issues

Stakeholder Feedback

Training Issues
- What is the evidence for having blended audience trainings in terms of effectiveness of the training? For example, if there is a targeted training on a type of clinical treatment, is it most effective to have all types of persons in the audience, including all professionals even if only one type of professional is going to do the treatment?
- Have programs focused on the redesign of professional services. This allows for training of consumers.
- Focus on care model and redesign. Make sure training and employment providers have the proper attitude: "It is not about me."
- Educate the public on MHSA values, goals and applications.

Organic Brain Issues
- Mental health services should be provided to clients at their cognitive level, appropriate to their disability or diagnosis.
- Organic brain differences need to be addressed by structured curriculum in skill building, rather than talk therapy.
- School district mental health counselors need to be trained in brain differences and organic brain dysfunction (which cause or create cognitive differences) and fetal alcohol spectrum disorders.
- Create a paradigm shift in therapeutic intervention models to create a neurobiological neuro-cognitive brain-based model.

Community Health Centers
- Use programs and CBOs that are involved in BPHC Health Disparities Collaborative programs.

- Identify programs in the community involved in the BPHC Health Disparities Collaboratives. Community Health Centers are first line of diagnosis and treatment for many consumers.

Other Issues

- OAC commissioners' responsibilities are not fulfilled and are superficial. OAC commissioners need to be more credible or accountable to the direct consumers and family members.
- Housing is needed in an overheated housing market. Gentrification is diminishing chances for mental health consumers' chances for housing.
- Financial incentives, such as reimbursement for employee release time.
- Some CBOs are currently under great pressure to bill. Unless the CBO gets paid for the time the employee spends in training, separate from the cost of the workshop, etc., it makes it a significant financial burden to the CBO.

VII. Small Group Discussions on Education and Training Key Issues

Stakeholders were also asked to propose model programs and qualifications for contractors in four key areas:

- Public mental health entry level preparation for consumers and family members
- Residency and internship programs
- Certification programs and
- Mental health career pathways

Each group was provided with a draft set of qualifications and asked to add relevant ones. Then they were asked to prioritize qualifications within each of the areas.

1. Public Mental Health Entry-Level Preparation for Consumers and Family Members

County mental health programs have submitted community services and supports plans that include a substantial number of positions specifically designated for individuals with consumer and family member experience. Short-term preparation programs are proposed to be funded that would provide orientation to service in public mental health, and would address issues of transition from consumer to provider of services, self-disclosure, reasonable accommodation, employment supports and benefits planning, among others.

Timeframe: 6 weeks to three months.

Scope: Any self-identified consumer or family member (different program for each) entering county or contract agency employment.

Framework: Can be conducted in a variety of settings, from the employer's site to adult education to ROP to community college, to a consumer or family run organization. The intent is for a prospective or current employer to sponsor participants in the training, so that successful completion of the program is tied directly to an employer's need.

Question #1: Who are existing entities with potential replicable programs?

Replicable Model Programs

California

- CalWORKs and Alliance for Workforce Development, Modoc County: choice of training
- Chrysalis, Santa Monica: consumer help to find jobs
- Client Network: What Do You Want? Finding Our Voice: self-help leadership training
- Communal Living Programs Housing Training
- CPRP Support Group, MHA of Sacramento County
- Effect of Government Entitlements, Los Angeles County
- EOC San Luis Obispo: independent living skills
- The Gibson Center, University of the Pacific, San Joaquin County: job training, skills building for volunteering, janitorial and clerical work; works with ConRep to keep people out of prison ("Incompetence to Stand Trial") and socialization program
- Jefferson Transition Program, Riverside
- Los Angeles County Client Coalition: empower clients to seek employment
- Life coach training
- NAMI: Consumer understanding; Peer to Peer: In Your Own Voice; Provider Training
- NEC video: Hiring Peers in the Workforce: the second half shows how to do it and addresses clients and what they need
- NPI – UCLA Fetal Alcohol Program; Mary O'Connor, MD
- On the job training
- Orange County CalWORKs
- Orange County Peers Empowering Peers
- Pacific Clinic/Pasadena City College: case managers and clients training; paraprofessional course; Anti-Stigma with Leadership/Toast Masters
- Peer Advocate Training, Los Angeles
- Phoenix/Anka, Contra Costa County: skills development for work, through homeless Shelter, MSC
- Project Back-Up, Los Angeles County: peer self advocacy concerning employment benefits
- ROP
- San Joaquin County Community Skills Program: employment preparation and wellness skills
- Self-Help Client-Run Programs, develop skills and volunteering
  - Berkeley Drop-In Center

  - Consumer Self-Help, Sacramento
  - Interlink, Sonoma
  - Oasis Community Center, San Francisco
  - Circle of Friends, Solano
- SPIRIT Best Now! Client-run to prepare clients who want to work in the mental health system. Also Best Now Latino
- Village Discovery Center, Los Angeles: replicate at colleges
- Vocational Rehabilitation and CMHS, Santa Barbara
- Wellness Recovery Center, Stanislaus County: support and education groups and peer support prepare consumers for job or education; build self-esteem

Out-of-State

- CONTAC Leadership Academy, West Virginia
- Core Competencies model, Georgia
- Meta Training, Arizona

Issues/Ideas

- Focus on those without high school diplomas. Start where the clients are. Help them earn a high school diploma.
- Promote volunteer work as initial entry to the workforce.
- Reach out to homeless people.
- Talk to foundations: they know community-based programs.
- Seek involvement of retired professionals.
- Gather client feedback on model programs.
- There is a refusal in some counties to use the educated and trained consumers and family members present in the community. Why? What is DMH doing to curb this trend?
- Disability students at community colleges.

Question #2: What experiences and qualifications should potential contractors have? Review range of qualifications and ask for additions.

Draft Qualifications	
First hand (CFM operated) experience as a CFM with consumers and family members in their recovery process.	57
History of successful experience with employment of consumers and family members throughout the organization.	31
Wellness and recovery orientation.	23
Cultural and linguistic and client culture competence and capacity; representation is a minimum standard: ask people what cultural competence looks like.	18
Demonstrated CFM experience.	12
Geographic accessibility throughout the state.	6
Academic qualifications where relevant; evidence of training and quality outcomes.	5
Advisory Board has Clients and Family members.	4
Demonstrated experience with mental health issues and clients.	2

Additional Qualifications Added at Meeting

Recognizes benefits for clients during employment and alternative payment systems.	21
Promotes non-traditional work structures and environments, is flexible to meet individual needs and is paid by the job.	20
Offers benefits and pay comparable to county employment (pay fits the job).	17
Program has demonstrated welcoming and respecting consumer providers. Management is sensitive to consumers and removes stigma.	9
Not only prepares clients to work, but also provides ongoing support, support groups, debriefs, continuing education and training.	9
Evidence of success employing and retaining CFMs.	6
Teaches confidentiality.	5
Not all medical model.	5
History of involvement with mental health issues, recovery, CFMs (not just for the money).	4
Schedules meetings for communication and support between contractor and consumer employees.	3
Overall organizational capacity track record with partners.	3
Experience with community models.	1

2. Residency and Internship Programs

County mental health programs have reported difficulty recruiting and retaining qualified individuals to prescribe and administer psychotropic medications, diagnose mental health conditions and sign treatment plans for Medi-Cal reimbursement. Replicable model programs are proposed to enable supervision of psychiatric residents and licensed interns in community public mental health settings that expand service provision while enabling participants to complete their programs.

Timeframe: Can be as little as two years for an internship program to five years for a residency program.

Scope: Can include any post-masters level to post-doctoral level that enables an individual to become licensed and capable of performing the above functions. Includes psychiatrists, physician assistants, advance practice nurses, social workers, psychologists, marriage and family therapists at the moment.

Framework: The emphasis here is that the participating individual be supervised in a community public mental health setting.

Question #1: Who are existing entities with potential replicable programs?

Replicable Model Programs

California

- Client Coalition
- Client Network
- CMHDA curriculum on community mental health vs. private practice model
- Cornerstone: trains clients to be mental health professionals
- Geriatric Social Work, Los Angeles
- Phillips Graduate Institute, Los Angeles County, especially Jose Lous: MFT placement
- Project Return
- Psychiatrists to intern at Wellness Center
- Southern California Consortium of Clinical Directors and Educators: stipend MFTs, similar to CalSWEC
- Stanford and UC Davis training for CHC primary care physicians (point of entry)
- UCLA residency program
- UCSF-Fresno program for underserved
- Welcome Back, San Francisco, Los Angeles and San Diego: evidence-based practices with internationally trained physicians to provide help with training. UCLA partnership with family practice, as well as a nurse licensure pathway to support case management (replicable to other tracks). Components include "English Health;" study groups and introduction to US health care system. They are currently developing a track for psychologists. It is not explicitly wellness and recovery focused.

Out-of-State

- Partners in Care, Hartford Foundation funded geriatric training

Issues/Ideas

Curriculum Alignment

- MFT programs have looked at relevance of curriculum and are realigning it, but other programs have not.
- Alignment of curricula and MHSA values in psychology and psychiatry programs.
- What is the curriculum vision?
- How can MHSA infuse its values into the curricula?
- CalSWEC has done work on curriculum realignment.
- Managing competing and additional county and school requirements is difficult and cumbersome.

Supervision/Mentoring

- Freeing up workforce to provide supervision.
- There is a lack of dedicated, paid, agency-based supervisors and field instructors.
- Child welfare is contracting supervision to prepare for licensing. Supervision is free with service obligation.

- It is already challenging to hire and recruit good supervisors.
- Include mentoring programs for clients re-entering the workforce.
- The impact of the supervisory role for internships is that clinicians are being taken out of their clinical role.
- Long Beach State, Cal State Los Angeles and San Francisco State have psychiatric nurse practitioner programs, but have struggles with placements and county requirements around insurance and liability.
- Address difficulties in establishing internships in contracting agencies.
- Who is training and recruiting supervisors? How does DMH align them with MHSA?
- Include supports in employment.

Licensing

- Licensing exams and requirements need to reflect community needs and provider qualifications should be consistent with MHSA.
- Licensing reflects the old medical model.
- Increase accommodations at BBS, the licensing board for MFTs and LCSWs.
- What is the role of the Department of Consumer Affairs in standardizing expectations and requirements?

Cultural Competence

- Include more advertising to diverse populations, including older adults.
- Include mentoring days for diverse populations, as well as awareness, newsletters and community outreach.
- DMH contracted CBOs all do trainings. Do not forget them, especially around special populations.
- Los Angeles County funded Amtrak to train Asians and Pacific Islanders around ten years ago.

Stipends/Tuition/Other Financing

- Provide fellowship grants, scholarships and tuition for individuals in exchange for service obligation for underserved populations in agencies, which have trouble recruiting staff.
- Provide more stipends and scholarships to promote greater diversity.
- Provide funding and create a pool of MHSA experts to assist in academic institutions.
- Provide central coordination so arrangements need not be made campus by campus.

Other Issues

- Have special programs for physician assistants and nurse practitioners.
- Start a DMH College.
- Need 24/7 call-in service for prescription questions.
- Need marriage and family training.

Question #2: What experiences and qualifications should potential contractors have? Review range of qualifications and ask for additions. Highest priority

Draft Qualifications	
Cultural and linguistic and client culture competence and capacity; representation is a minimum standard: ask people what cultural competence looks like.	20
Demonstrated experience with mental health issues and clients.	16
Wellness and recovery orientation.	12
Geographic accessibility throughout the state.	8
History of successful experience with employment of consumers and family members throughout the organization.	4
Demonstrated CFM experience.	3
Academic qualifications where relevant; evidence of training and quality outcomes.	1

Additional Qualifications Added at Meeting

Evidence that curriculum explicitly reflects and is infused with values of CMH and MHSA.	11
Experience with specific populations, including transition age youth and older adults.	7
Knowledge of regulations and bureaucracy.	6
Commitment to train good supervisors.	5
Evaluation model and component (have capacity to evaluate effects of services).	3
Flexibility with needs of professionals (distance learning, flexible time).	2
Familiarity with human resources, disability, legal issues, ethics to support completion of training program.	2
Special training programs for supervisors with MHSA values and environments.	1

3. Certification Programs

The Mental Health Services Act promotes service provision that embraces a strengths based, culturally competent consumer driven approach that has a focus on wellness, recovery and resilience. The psychosocial rehabilitation model espouses a set of principles and practices that commits to the fundamental principle that persons with serious mental illness can and do recover, rejoin the community and lead productive lives. Replicable model programs, with a focus on the community college setting, are proposed to field short-term psychosocial rehabilitation training programs that would enable new and current employees at all levels of service delivery to acquire proficiency in the principles and practices of psychosocial rehabilitation.

Timeframe: Up to a semester in length.

Scope: For any prospective or currently employed community public mental health individual, or any individual who partners with a community public mental health program by providing primary care, first response, or support to consumers and family members.

Framework: The focus is on community colleges as the setting, but can be delivered by any appropriate trainer.

Question #1: Who are existing entities with potential replicable programs?

Replicable Model Programs

California

- California Association of Social Rehabilitation Agencies (CASRA): 5 course curriculum offered to work with community colleges
- Cerritos College: mental health worker certificate program
- CPRP, Solano County: National expanded program
- Department of Consumer Affairs, Los Angeles County: Peer support certificate
- Evidence Based Practices Alternative Conference 2005
- Jefferson Transitional Program, Riverside: peer training for employment; not sure if it is a certificate program
- MHA, Orange County: annual conference on the meeting of the minds
- NAMI: parent education called Family to Family could be expanded; Peer to Peer program, as well as multi-tiered approach to planning
- Pasadena City College for consumers to be peer supports
- Pierce College, Woodland Hills: organic brain differences
- Project Return, Los Angeles County: consumer based
- Self-Help Client-Run Programs, develop skills and volunteering
  - Alameda Peer
  - Interlink, Sonoma
  - Oasis Community Center, San Francisco
- Solano Community College and Santa Rosa Junior College Human Services Certificate and Associate Degree
- SPIRIT Program, Contra Costa County: for clients and family members, based on recovery and wellness
- University of the Pacific and Delta College, San Joaquin County: community skill building, bilingual program
- USC School of Social Work: opportunities to be guest speaker
- Wellness Recovery Center, Stanislaus County: peer and re-entry and recovery

Out-of-State

- META, Arizona: post-secondary education leading to AA degree
- Peer support specialist certificate, Pennsylvania and Georgia
- USPRA – national
- Wellness Recovery Action Plan (WRAP), Arizona

Issues

- LVN psychiatric technician, possibly? Certificates must be monetarily compensated.

Question #2: What experiences and qualifications should potential contractors have? Review range of qualifications and ask for additions.

Draft Qualifications	
Academic qualifications where relevant; evidence of training and quality outcomes.	17
Cultural and linguistic and client culture competence and capacity; representation is a minimum standard: ask people what cultural competence looks like.	14
History of successful experience with employment of consumers and family members throughout the organization.	14
First hand (CFM operated) experience as a CFM with consumers and family members in their recovery process.	13
Wellness and recovery orientation.	12
Demonstrated experience with mental health issues and clients.	11
Demonstrated CFM experience.	8
Geographic accessibility throughout the state.	5

Additional Qualifications Added at Meeting

Understands mission and vision of MHSA.	10
Demonstrated experience working with non-traditional under-represented unserved and inappropriately served populations; expertise in the population.	9
Students may receive credit for life experience and internships.	6
Certificates must potentially be state recognized.	5
Flexible programs and services.	2

4. Mental Health Career Paths

The Act stipulates that programs be established that encourage individuals to consider careers in public mental health. Replicable model programs are proposed to be established in high schools, regional occupational programs and adult education settings that would provide outreach to youth in underserved communities, and blend academics with hands-on exposure to working in public mental health.

Timeframe: Can be as little as a subject matter focus in a health career track in an educational setting, up to a course throughout a high school student's four years; or can be a stand-alone program that integrates with a student's high school experience.

Scope: Primary focus is on at-risk transition age youth in underserved communities, but can be also for adults returning to the workforce through adult education or ROP, and needing exposure to public mental health as a career.

Framework: Settings are high schools, adult ed or ROP programs.

Question #1: Who are existing entities with potential replicable programs?

Replicable Model Programs

California

- Benefits Assistance, Los Angeles
- California Department of Education representative on workgroup is looking at adjusting existing high school course to steer toward mental health careers
- California schools of social work have career ladder from AA to Ph.D.
- CASRA: Betty Dalquist, Executive Director, has a curriculum that incorporates wellness and recovery principles. Counties can purchase in partnership with community colleges.
- Cerritos College: mental health worker training program
- Client Network: Assists consumers and trains them to be trainers for the system; "What Do You Want?" workshops (Michele Curran)
- Community centers in Contra Costa County run by consumers provide support, lunch, etc.
- Contra Costa County Patient rights advocacy for people in long-term care or hospitals done by consumers
- Counselor-educators in CSU system have a curriculum that could be replicated. Need advocacy with BBS for license.
- CSU Dominguez Hills: BA in human services with specialty in mental health
- Family Partners, Contra Costa County
- High school and ROP course: certificate in mental health, including transition planning
- Jump Start, CSU Pomona Hills: 12-15 week program prepared to enter mental health system, provides supports
- Life Coach Training workshop, West Central Los Angeles. Contact Dr. Michael Walker.
- NAMI could create mentoring program based on Peer to Peer
- NAMI – Los Angeles: "In Our Own Voice" consumer-to-consumer anti-stigma program
- NAMI Family to Family Program
- Oakland Regional Life Science Academy, Erik Rice
- Pacific Clinics: Susan Mandel, Executive Director, has conducted research
- Pacific Clinics, Pasadena City College together encourage clients to become mental health workers
- Pathways to Recovery, San Bernardino
- Peer Advocates, Los Angeles
- Project Return Next Steps, Los Angeles: client run program for peer advocacy training
- Prototypes Los Angeles: employs and trains clients
- San Joaquin County Department of Rehabilitation: community skills building prepares people to work and helps with symptoms management

- SPIRIT Training, Contra Costa County: could be modified for high school and ROP levels; prepares consumers to work in mental health field
- TEAMS training for advocacy and motivation, Contra Costa County: support at community colleges led by SPIRIT graduates
- Telecare has been successful at hiring and retaining consumers. Contact Robert Klar
- TLC, Contra Costa County: consumers are hired to help other consumers with daily activities
- UCLA MPI FAS Clinic
- The Village, Los Angeles: client run program
- Welcome Back, San Francisco, San Diego and Los Angeles: helps bilingual foreign trained providers re-enter health workforce
- Wellness Centers, Riverside: peer specialists certified in forty days
- WRAP Specialists, Contra Costa County

Issues/Ideas

- Need help reaching out to the cultural groups. What is the right approach?
- Panels of county mental health, consumers and family members can go to community colleges to inform them of resources and to build relationships.
- Contractors should be strongly knowledgeable of MHSA.
- Gifted and Talented Education (GATE) students could be enrolled.

Question #2: What experiences and qualifications should potential contractors have? Review range of qualifications and ask for additions.

Draft Qualifications	
Cultural and linguistic and client culture competence and capacity; representation is a minimum standard: ask people what cultural competence looks like.	42
Demonstrated experience with mental health issues and clients.	41
History of successful experience with employment of consumers and family members throughout the organization.	31
Wellness and recovery orientation.	24
First hand (consumer and family member operated) experience as a consumer and family member with consumers and family members in their recovery process.	17
Academic qualifications where relevant; evidence of training and quality outcomes.	8
Demonstrated consumer and family member experience.	7
Advisory Board has consumer and family member members.	4
Geographic accessibility throughout the state.	3

Additional Qualifications Added at Meeting

Expertise in mentoring.	16

Able to link multiple levels of education.	16
Strong data and research evidence of outcomes.	9
Supports for consumer and family members.	8
Knowledgeable about benefits throughout the organization.	4
Easy access to protection of client rights.	2
Consumers and family members are the trainers.	1
Knowledge of ADA reasonable accommodations.	1
Experience with supported employment and tracking employment process outcomes.	1

Additional Stakeholder Feedback

- I did not participate in the small group discussions. I think this effort is starting with the wrong questions. Replicable programs – those already in existence? MHSA needs transformational programs, which may not exist yet. Core issues are being ignored. Clients and family members need to create programs, which answer their needs for self, family and community. Counties and DMH need to go out to the communities to find out what they need or want. Listen to their stories and develop programs from the diverse communities themselves. Programs need to deal with multiple levels of trauma. Personal trauma as a client, a family member as well as a clinician, personal experiences of trauma as a member of a dysfunctional family, community, system and society as a client or clinician. Until these interconnections are acknowledged and made conscious we have a lot of work to do. Both the system(s) and the consumers need to deal with worldview changes, the paradigm shift. It is process-oriented. A shift away from control, manipulation, etc., is what education and training needs to be about. It has not happened yet or very minimally. Replicable programs barely exist at this point in the new paradigm-world view shift. If the core is not to acknowledge this, we will not get very far.
- During the small group discussions at the September 25 meeting in Sacramento, five participants formed a discussion group to discuss ethics in regards to education and training.
- The small group process is starting with the wrong questions.
- A better question is how to assure that MHSA education and training promotes voluntary treatment.
- It is worth having a voice about ethics.
- When the matter comes up, the professionals say they already have ethics, so that will suffice. MHSA must build ethics based on community relations.
- Norma Haan, a researcher at UC Berkeley, developed and developed “interactional” alternative to Kohlberg’s version of moral psychology. Rather than speaking of “Light bulbs,” seeing the “light,” Haan developed a clearer morality than Kohlberg or Piaget developed, based on how people relate.
- Ethics involves people taking one-another seriously as people. There is a clinician at Mendocino Mental Health who does so. The ethical way is to care about the meaning of the interaction. In general, providers do not understand this model.

- An example of unethical behavior in the education system is the client activist who was admitted to Fresno State's MSW program. He was informed that his first obligation was to be compliant to the system. As a result, he abandoned the program.
- An example of a successful program is the UC Davis Native Studies, which includes some instructors retain their "Indian-ness." MHSA needs to develop and enforce ethical criteria for recruiting people into training programs, so that this kind of level can be attained.
- An example of ethical issues in regards to training and hiring consumers is the client Case Manager in a county who decompensated due to performance expectation stress. He started drinking again and finally killed himself.
- There is a problem for consumers about the standard for consumer ethics. The system has its own ethical concerns, but gives no note or value to the ethics of being a 'client' advocate.

VIII. Dates of Upcoming Conference Calls and General Stakeholder Meetings

October 17	3:00 Conference Call, Capital, IT and Housing
October 23	Fresno General Stakeholder Meeting
October 24	Los Angeles General Stakeholder Meeting
December 6	Orange County General Stakeholder Meeting
December 7	Oakland General Stakeholder Meeting